

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034530

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2498

FILED AUG 19 1963

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 4030

2 1910

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USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Moline</b>		c. CITY OR TOWN <b>Flat River</b>	
Length of stay in 1b <b>5 weeks</b>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Halls Ferry Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>506 W. Main</b>	
3. NAME OF DECEASED (Type or print) <b>Nora Mintner</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never-Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (City and state or country) <b>Belgrade, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Joseph Hardin</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Mosier</b>	
14. NAME OF HUSBAND OR WIFE <b>Unavailable</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Jack Mintner, 6808 St. Olaf</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Debris cerebral bleeding of unknown origin</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <b>7:27</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <b>Leadwood, Mo.</b>	
21. I attended the deceased from <b>June 29, 1963</b> to <b>Aug. 4, 1963</b> and last saw her alive on <b>July 12, 1963</b> Death occurred at <b>7:27 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Raymond A. Staushagen MD</b>		22b. ADDRESS <b>3121 N. Grand St. Louis 7, Mo.</b>	
22c. DATE SIGNED <b>8-5-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-6-63</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>		23d. LOCATION (City, town, or county) <b>Leadwood, Mo.</b>	
24. FUNERAL DIRECTOR <b>Boyer Funeral Home, Leadwood, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>8-6-63</b>	
26. REGISTRAR'S SIGNATURE <b>John B. Murphy MD</b>			

(Licensed Embalmer's Statement on Reverse Side)

AUG 21 1963

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.